2012

CUMULATIVE SUPPLEMENT

TO

MISSISSIPPI CODE

1972 ANNOTATED

Issued September, 2012

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ENACTED THROUGH THE 2012 REGULAR SESSION

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User's Guide

In order to assist both the legal profession and the layman in obtaining the maximum benefit from the Mississippi Code of 1972 Annotated, a User's Guide has been included in the main volume. This guide contains comments and information on the many features found within the Code intended to increase the usefulness of the Code to the user.

PUBLISHER'S FOREWORD

Statutes

The 2012 Supplement to the Mississippi Code of 1972 Annotated reflects the statute law of Mississippi as amended by the Mississippi Legislature through the end of the 2012 Regular Session.

Annotations

Case annotations are included based on decisions of the State and federal courts in cases arising in Mississippi. Annotations to collateral research references are also included.

To better serve our customers by making our annotations more current, LexisNexis has changed the sources that are read to create annotations for this publication. Rather than waiting for cases to appear in printed reporters, we now read court decisions as they are released by the courts. A consequence of this more current reading of cases, as they are posted online on LexisNexis, is that the most recent cases annotated may not yet have print reporter citations. These will be provided, as they become available, through later publications.

This publication contains annotations taken from decisions of the Mississippi Supreme Court and the Court of Appeals and decisions of the appropriate federal courts. These cases will be printed in the following reporters:

Southern Reporter, 3rd Series
United States Supreme Court Reports
Supreme Court Reporter
United States Supreme Court Reports, Lawyers' Edition, 2nd Series
Federal Reporter, 3rd Series
Federal Supplement, 2nd Series
Federal Rules Decisions
Bankruptcy Reporter

Additionally, annotations have been taken from the following sources:

American Law Reports, 6th Series
American Law Reports, Federal Series
Mississippi College Law Review
Mississippi Law Journal

Finally, published opinions of the Attorney General and opinions of the Ethics Commission have been examined for annotations.

Amendment Notes

Amendment notes detail how the new legislation affects existing sections.

Editor's Notes

Editor's notes summarize subject matter and legislative history of repealed sections, provide information as to portions of legislative acts that have not been codified, or explain other pertinent information.

Joint Legislative Committee Notes

Joint Legislative Committee notes explain codification decisions and corrections of Code errors made by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation.

Tables

The Statutory Tables volume adds tables showing disposition of legislative acts through the 2012 Regular Session.

Index

The comprehensive Index to the Mississippi Code of 1972 Annotated is replaced annually, and we welcome customer suggestions. The foreword to the Index explains our indexing principles, suggests guidelines for successful index research, and provides methods for contacting indexers.

Acknowledgements

The publisher wishes to acknowledge the cooperation and assistance rendered by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation, as well as the offices of the Attorney General and Secretary of State, in the preparation of this supplement.

User Information

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For further information or assistance, please call us toll-free at (800) 833-9844, fax us toll-free at (800) 643-1280, e-mail us at customer.support@bender.com, or write to: Mississippi Code Editor, LexisNexis, 701 E. Water Street, Charlottesville, VA 22902-5389.

September 2012 LexisNexis

SCHEDULE OF NEW SECTIONS

Added in this Supplement

ACCIDENT AND HEALTH INSURANCE

MISSISSIPPI CODE 1972

ANNOTATED

VOLUME NINETEEN

TITLE 83

INSURANCE

CHAPTER 1

Department of Insurance

GENERAL PROVISIONS

§ 83-1-5. Compensation and employees.

The commissioner shall receive a compensation to be fixed by law. He is hereby authorized to employ a clerk and stenographer and an actuary at a salary to be fixed by law; and in addition shall be allowed a sufficient sum for traveling expenses and for extra clerical help.

Further, the commissioner may appoint or employ special counsel pursuant to the provisions of Section 7-5-39.

SOURCES: Codes, 1906, § 2553; Hemingway's 1917, § 5017; 1930, § 5116; 1942, § 5618; Laws, 1926, ch. 345; reenacted without change, Laws, 1982, ch. 375, § 2; reenacted without change, Laws, 1990, ch. 559, § 3; reenacted without change, Laws, 1996, ch. 313, § 3; Laws, 2012, ch. 546, § 42, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added the last paragraph.

COMPREHENSIVE HURRICANE DAMAGE MITIGATION PROGRAM

SEC.

§ 83-1-191. Comprehensive hurricane damage mitigation program established; cost-benefit study on wind hazard mitigation construction measures; inspections; financial grants for residential retrofits; public education; advisory council; rules and regulations [Repealed effective July 1, 2015].

(1) There is established within the Department of Insurance a Comprehensive Hurricane Damage Mitigation Program. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property or commercial property in this state. Implementation of this program is subject to the availability of funds that may be appropriated by the Legislature for this purpose. The program may develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

(a) **Cost-benefit study on wind hazard mitigation construction measures.** — The performance of a cost-benefit study to establish the most appropriate wind hazard mitigation construction measures for both new construction and the retrofitting of existing construction for both residential and commercial facilities within the wind-borne debris regions of Mississippi as defined by the International Building Code. The recommended wind construction techniques shall be based on both the newly adopted Mississippi building code sections for wind load design and the wind-borne debris region. The list of construction measures to be considered for evaluation in the cost-benefit study shall be based on scientifically established and sound, but common, construction techniques that go above and beyond the basic recommendations in the adopted building codes. This allows residents to utilize multiple options that will further reduce risk and loss and still be awarded for their endeavors with appropriate wind insurance discounts. It is recommended that existing accepted scientific studies that validate the wind hazard construction techniques benefits and effects be taken into consideration when establishing the list of construction techniques that homeowners and business owners can employ. This will ensure that only established construction measures that have been studied and modeled as successful mitigation measures will be considered to reduce the chance of including risky or unsound data that will cost both the property owner and state unnecessary losses. The cost-benefit study shall be based on actual construction cost data collected for several types of residential construction and commercial construction materials, building techniques and designs that are

common to the region. The study shall provide as much information as possible that will enhance the data and options provided to the public, so that homeowners and business owners can make informed and educated decisions as to their level of involvement. Based on the construction data, modeling shall be performed on a variety of residential and commercial designs, so that a broad enough representative spectrum of data can be obtained. The data from the study will be utilized in a report to establish tables reflecting actuarially appropriate levels of wind insurance discounts (in percentages) for each mitigation construction technique/combination of techniques. This report will be utilized as a guide for the Department of Insurance and the insurance industry for developing actuarially appropriate discounts, credits or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. Additional data that will enhance the program, such as studies to reflect property value increases for retrofitting or building to the established wind hazard mitigation construction techniques and cost comparison data collected to establish the value of this program against the investment required to include the mitigation measures, also may be provided.

(b) **Wind certification and hurricane mitigation inspections.**

(i) Home-retrofit inspections of site-built, residential property, including single-family, two-family, three-family or four-family residential units, and a set of representative commercial facilities may be offered to determine what mitigation measures are needed and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. A state program may be established within the Department of Insurance to provide homeowners and business owners wind certification and hurricane mitigation inspections. The inspections provided to homeowners and business owners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies corrective actions a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the mitigation features.

3. Insurer-specific information regarding premium discounts correlated to recommended mitigation features identified by the inspection.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities.

This data may be provided by trained and certified inspectors in standardized reporting formats and forms to ensure all data collected during inspections is equivalent in style and content that allows construction data, estimates and discount information to be easily assimilated into a database. Data pertaining to the number of inspections and inspection reports may be stored in a state database for evaluation of the program's success and review of state goals in reducing wind hazard loss in the state.

(ii) To qualify for selection by the department as a provider of wind certification and hurricane mitigation inspections services, the entity shall, at a minimum, and on a form and in the manner prescribed by the commissioner:

1. Use wind certification and hurricane mitigation inspectors who:

a. Have prior experience in residential and/or commercial construction or inspection and have received specialized training in hurricane mitigation procedures through the state certified program. In order to qualify for training in the inspection process, the individual should be either a licensed building code official, a licensed contractor or inspector in the State of Mississippi, or a civil engineer.

b. Have undergone drug testing and background checks.

c. Have been certified through a state mandated training program, in a manner satisfactory to the department, to conduct the inspections.

d. Have not been convicted of a felony crime of violence or of a sexual offense; have not received a first-time offender pardon or nonadjudication order for a felony crime of violence or of a sexual offense; or have not entered a plea of guilty or nolo contendere to a felony charge of violence or of a sexual offense.

e. Submit a statement authorizing the Commissioner of Insurance to order fingerprint analysis or any other analysis or documents deemed necessary by the commissioner for the purpose of verifying the criminal history of the individual. The commissioner shall have the authority to conduct criminal history verification on a local, state or national level, and shall have the authority to require the individual to pay for the costs of such criminal history verification.

2. Provide a quality assurance program including a reinspection component.

3. Have data collection equipment and computer systems, so that data can be submitted electronically to the state's database of inspection reports, insurance certificates, and other industry information related to this program. It is mandatory that all inspectors provide original copies to the property owner of any inspection reports, estimates, etc., pertaining to the inspection and keep a copy of all inspection materials on hand for state audits.

(c) **Financial grants to retrofit properties.** — Financial grants may be used to encourage single-family, site-built, owner-occupied, residential property owners or commercial property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(d) **Education and consumer awareness.** — Multimedia public education, awareness and advertising efforts designed to specifically address mitigation techniques may be employed, as well as a component to support ongoing consumer resources and referral services. In addition, all insurance companies shall provide notification to their clients regarding the availability of this program, participation details, and directions to the state website

promoting the program, along with appropriate contact phone numbers to the state agency administrating the program. The notification to the clients must be sent by the insurance company within thirty (30) days after filing their insurance discount schedules with the Department of Insurance.

(e) **Advisory council.** — There is created an advisory council to provide advice and assistance to the program administrator with regard to his or her administration of the program. The advisory council shall consist of:

(i) An agent, selected by the Independent Insurance Agents of Mississippi.

(ii) Two (2) representatives of residential property insurers, selected by the Department of Insurance.

(iii) One (1) representative of homebuilders, selected by the Home Builders Association of Mississippi.

(iv) The Chairman of the House Insurance Committee, or his designee.

(v) The Chairman of the Senate Insurance Committee, or his designee.

(vi) The Executive Director of the Mississippi Windstorm Underwriting Association, or his designee.

(vii) The Director of the Mississippi Emergency Management Agency, or his designee.

Members appointed under subparagraphs (i) and (ii) shall serve at the pleasure of the Department of Insurance. All other members shall serve as voting ex officio members. Members of the advisory council who are not legislators, state officials or state employees shall be compensated at the per diem rate authorized by Section 25-3-69, and shall be reimbursed in accordance with Section 25-3-41, for mileage and actual expenses incurred in the performance of their duties. Legislative members of the advisory council shall be paid from the contingent expense funds of their respective houses in the same manner as provided for committee meetings when the Legislature is not in session; however, no per diem or expense for attending meetings of the advisory council may be paid while the Legislature is in session. No advisory council member may incur per diem, travel or other expenses unless previously authorized by vote, at a meeting of the council, which action shall be recorded in the official minutes of the meeting. Nonlegislative members shall be paid from any funds made available to the advisory council for that purpose.

(f) **Rules and regulations.** — The Department of Insurance may adopt rules and regulations governing the Comprehensive Hurricane Damage Mitigation Program. The department also may adopt rules and regulations establishing priorities for grants provided under this section based on objective criteria that gives priority to reducing the state's probable maximum loss from hurricanes. However, pursuant to this overall goal, the department may further establish priorities based on the insured value of the dwelling, whether or not the dwelling is insured by the Mississippi Windstorm Underwriting Association and whether or not the area under

consideration has sufficient resources and the ability to perform the retrofitting required.

(2) Nothing in this section shall prohibit the Department of Insurance from entering into an agreement with any other appropriate state agency to assist with or perform any of the duties set forth hereunder.

(3) This section shall stand repealed from and after July 1, 2015.

SOURCES: Laws, 2007, ch. 524, § 4; Laws, 2009, ch. 537, § 1; Laws, 2010, ch. 313, § 1; Laws, 2012, ch. 307, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment extended the repealer provision in (3), from "July 1, 2012" to "July 1, 2015."

CHAPTER 5

General Provisions Relative to Insurance and Insurance Companies

PERIODIC FINANCIAL EXAMINATIONS OF INSURERS

SEC.

§ 83-5-205. Examination of insurers; scheduling of examinations; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state.

(1) The commissioner or any of his examiners may conduct an examination under Sections 83-5-201 through 83-5-217 of any company as often as the commissioner, in his or her sole discretion, deems appropriate but, at a minimum, shall conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the commissioner exercises discretion under this section.

(2) For purposes of completing an examination of any company under Sections 83-5-201 through 83-5-217, the commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation, in the sole discretion of the commissioner, is necessary or material to the examination of the company.

(3) In lieu of an examination under Sections 83-5-201 through 83-5-217 of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if (a) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or (b) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

SOURCES: Laws, 1992, ch. 319, § 3; Laws, 2012, ch. 364, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment substituted "five (5)" for "three (3)" at the end of the first sentence of (1).

PROPERTY AND CASUALTY ACTUARIAL OPINION ACT

SEC.
83-5-507. Repealed.

§ 83-5-501. Title.

SOURCES: Laws, 2009, ch. 441, § 1; reenacted without change, Laws, 2012, ch. 306, § 1, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-503. Actuarial opinion of reserves and supporting documentation.

SOURCES: Laws, 2009, ch. 441, § 2; reenacted without change, Laws, 2012, ch. 306, § 2, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-505. Confidentiality.

SOURCES: Laws, 2009, ch. 441, § 3; reenacted without change, Laws, 2012, ch. 306, § 3, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-507. Repealed.

Repealed by Laws of 2012, ch. 306, § 4, effective July 1, 2012.

§ 83-5-507. [Laws, 2009, ch. 441, § 4, eff from and after Jan. 1, 2010.]

Editor's Note — Former § 83-5-507 would have repealed §§ 83-5-501 through 83-5-507, effective July 1, 2012.

CHAPTER 9

Accident, Health and Medicare Supplement Insurance

ACCIDENT AND HEALTH INSURANCE

§ 83-9-5. Policy provisions.

(1) **Required provisions.** — Except as provided in subsection (3) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one or more of such provisions, corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

As used in this section, the term "insurer" means a health maintenance organization, an insurance company or any other entity responsible for the payment of benefits under a policy or contract of accident and sickness insurance; however, the term "insurer" shall not mean a liquidator, rehabilitator, conservator or receiver or third party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation

proceedings, nor shall it mean any responsible guaranty association. Further, no cause of action shall accrue against a liquidator, rehabilitator, conservator or receiver or third-party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation proceedings or any responsible guaranty association under paragraph (h)(3) of this susection or any policy provision in accordance therewith.

(a) A provision as follows:

Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(b) A provision as follows:

Time limit on certain defenses:

1. After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(The foregoing policy provision shall not be so construed as to effect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subsections (2)(a) and (2)(b) of this section in the event of misstatement with respect to age or occupation.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements in the application.)

2. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) A provision as follows:

Grace period:

A grace period of seven (7) days for weekly premium policies, ten (10) days for monthly premium policies and thirty-one (31) days for all other policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than five (5) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.")

(d) A provision as follows:

Reinstatement:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.)

(e) A provision as follows:

Notice of claim:

Written notice of claim must be given to the insurer within thirty (30) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may, at its option, insert the following between

the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.")

(f) A provision as follows:

Claim forms:

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(g) A provision as follows:

Proofs of loss:

Written proof of loss must be furnished to the insurer at its said office, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within ninety (90) days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(h) A provision as follows:

Time of payment of claims:

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean

claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the

insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly), and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of one and one-half percent (1-½%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

4. In the event the insurer fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in paragraph (h)(3) of this subsection and any other damages as may be allowable by law.

(i) A provision as follows:

Payment of claims:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. The notification requirement shall not apply to a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which must not exceed One Thousand Dollars ($1,000.00)), to any relative by blood or connection by marriage of the

insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person").

(j) A provision as follows:

Physical examinations:

The insurer at his own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

(k) A provision as follows:

Legal actions:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(*l*) A provision as follows:

Change of beneficiary:

Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(2) **Other provisions.** — Except as provided in subsection (3) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. However, the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

Change of occupation:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that

stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the most recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable, or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(b) A provision as follows:

Misstatement of age:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(c) A provision as follows:

Relation of earnings to issuance:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case

of a policy issued after age forty-four (44), for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulations by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner, or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations).

(d) A provision as follows:

Unpaid premium:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(e) A provision as follows:

Cancellation:

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five (5) days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(f) A provision as follows:

Conformity with state statutes:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(g) A provision as follows:

Illegal occupation:

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(h) A provision as follows:

Intoxicants and narcotics:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(3) **Inapplicable or inconsistent provisions.** — If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) **Order of certain policy provisions.** — The provisions which are the subject of subsections (1) and (2) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued.

(5) **Third-party ownership.** — The word "insured," as used in Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured, or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(6) **Requirements of other jurisdictions.** —

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(7) **Filing procedure.** — The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to the cited sections as are necessary, proper or advisable to the administration of said sections. This provision shall not abridge any other authority granted the commissioner by law.

(8) **Administrative penalties.** —

(a) If the commissioner finds that an insurer, during any calendar year, has paid at least eighty-five percent (85%), but less than ninety-five percent (95%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not to exceed Ten

Thousand Dollars ($10,000.00). If the commissioner finds that an insurer, during any calendar year, has paid at least fifty percent (50%), but less than eighty-five percent (85%), of all clean claims received from all providers during that year in accordance with the provision of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount of not less than Ten Thousand Dollars ($10,000.00) nor more than One Hundred Thousand Dollars ($100,000.00). If the commissioner finds that an insurer, during any calendar year, has paid less than fifty percent (50%) of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not less than One Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred Thousand Dollars ($200,000.00). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in subsection (1)(h) of this section were due to circumstances beyond the control of the insurer. The insurer may request an administrative hearing to contest the assessment of any administrative penalty imposed by the commissioner pursuant to this subsection within thirty (30) days after receipt of the notice of assessment.

(b) Examinations to determine compliance with subsection (1)(h) of this section may be conducted by the commissioner or any of his examiners. The commissioner may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the insurer examined.

(c) Nothing in the provisions of subsection (1)(h) of this section shall require an insurer to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance.

(d) An insurer and a provider may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (1)(h) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the insurer to the provider. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (1)(h)3 of this section shall apply.

(e) The commissioner may adopt rules and regulations necessary to ensure compliance with this subsection.

SOURCES: Codes, 1942, § 5687-03; Laws, 1956, ch. 330, § 3; Laws, 1989, ch. 466, § 1; Laws, 1991, ch. 474, § 2; Laws, 2002, ch. 575, § 1, eff from and after Jan. 1, 2003.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected errors in this section. Corrected reference terminology in (1), (1)(b)1 and (1)(h) 4. The Joint Committee ratified the corrections at its August 16, 2012, meeting.

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

SEC.
83-9-211. Creation of association; membership; board of directors; adoption of plan, articles, bylaws and operating rules.

§ 83-9-211. Creation of association; membership; board of directors; adoption of plan, articles, bylaws and operating rules.

(1) There is created a nonprofit legal entity to be known as the "Comprehensive Health Insurance Risk Pool Association." All insurers, as a condition of doing business, shall be members of the association.

(2)(a) The association shall operate subject to the supervision and approval of an eleven-member board of directors consisting of:

(i) Six (6) members appointed by the Insurance Commissioner. Two (2) of the commissioner's appointees shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer. Two (2) appointees shall be representatives of medical providers. One (1) appointee shall be a representative of businesses employing fewer than one hundred (100) employees. One (1) appointee shall be a representative of health insurance agents. Any board member appointed by the commissioner may be removed and replaced by him at any time without cause.

(ii) Three (3) members appointed by the participating insurers, at least one (1) of whom is a domestic insurer.

(iii) The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee, or their designees, who shall be nonvoting, ex officio members of the board.

(iv) Of those initial members appointed by the Insurance Commissioner, one (1) shall serve for a term of one (1) year, two (2) for a term of two (2) years, and one (1) for a term of three (3) years. Of those initial members appointed by the participating insurers, one (1) shall serve for a term of one (1) year, one (1) shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

(v) All appointments after the initial term shall be for a term of three (3) years.

(b) The board of directors shall elect one (1) of its members as chairman.

(c) Board members may be reimbursed from monies of the association for actual and necessary expenses incurred by them as members in the manner and amount provided in Section 25-3-41, Mississippi Code of 1972, but shall not otherwise be compensated for their services.

(3) The association shall adopt a plan in accordance with Sections 83-9-201 through 83-9-222 and submit its articles, bylaws and operating rules to the State Department of Insurance for approval. If the association fails to

adopt such plan and suitable articles, bylaws and operating rules within ninety (90) days after the appointment of the board, the State Department of Insurance shall adopt rules to effectuate the provisions of Sections 83-9-201 through 83-9-222; and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the association and approved by the State Department of Insurance.

(4) Individual board members shall not be liable and shall be immune from suit at law or equity for any conduct performed in good faith and which is within the subject matter over which they have been given jurisdiction.

SOURCES: Laws, 1991, ch. 593, § 6; Laws, 1995, ch. 490, § 6; reenacted and amended, Laws, 1997, ch. 311, § 6; Laws, 2009, ch. 385, § 4; Laws, 2012, ch. 302, § 1, eff from and after passage (approved Mar. 30, 2012.)

Amendment Notes — The 2012 amendment substituted "an eleven-member" for "a nine-member" preceding "board of directors consisting of" at the end of (2)(a); in (2)(a)(i), substituted "Six (6)" for "Four (4)" at the beginning of first sentence, "Two (2)" for "One (1)" at beginning of third sentence, added fourth sentence, and made minor stylistic changes; inserted "initial" preceding "members" in the first and second sentences in (2)(a)(iv); substituted "appointments" for "terms" and "term" for "period" in (2)(a)(v).

CHAPTER 11

Automobile Insurance

Article 1.

Cancellation or Nonrenewal of Policy.

§ 83-11-5. Notice of cancellation.

JUDICIAL DECISIONS

1. In general.

Insurer had an arguable reason for its actions of canceling the insurance coverage after the insurer failed to pay a monthly premium because the Commissioner of Insurance's interpretation of Miss. Code Ann. § 83-11-5, that it was understood as a requirement of reminding customers at least 10 days in advance that they should either timely pay their premiums or make alternative arrangements before the coverage in place expires, was not contrary to the statute's plain language. Keys v. Safeway Ins. Co., — F. Supp. 2d —, 2011 U.S. Dist. LEXIS 13197 (S.D. Miss. Feb. 9, 2011).

Article 11.

Payment of Claims.

Sec.

payee on check; obtaining title where there is total loss settlement [Repealed effective July 1, 2014].

§ 83-11-551. Addition of name of business repairing automobile or lienholder as payee on check; obtaining title where there is total loss settlement [Repealed effective July 1, 2014].

(1) In cases in which there is not a total loss, when there are one or more lienholders shown in the policy or confirmed in writing by the insured before the loss, an insurer paying a claim under automobile physical damage coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the business or other entity repairing the automobile or the name of the lienholder or lienholders.

(2) In cases of a total loss, when there are one or more lienholders (a) shown in the policy, (b) confirmed in writing by the insured before the loss, or (c) shown on the vehicle title recorded with the Mississippi Department of Revenue, an insurer paying a claim under automobile physical damage coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the lienholder or lienholders.

(3) If the insured disputes the existence of any lien, it is the insured's responsibility to have the liens released. When payment is made to a lienholder, the lienholder shall pay any balance owed to the debtor within thirty (30) days after receipt of the check. However, in the case of a total loss, the insurer may issue separate checks to the lienholder and to the insured for the amount of each party's financial interest in the vehicle. This section shall not apply to the repair or replacement of glass in the vehicle.

(4) If an insurance company makes a total loss settlement on a motor vehicle, the owner or lienholder of the motor vehicle shall forward the properly endorsed certificate of title to the insurance company within fifteen (15) days after receipt of the settlement funds.

(5)(a) If an insurance company is unable to obtain the properly endorsed certificate of title within thirty (30) days after disbursing a total loss settlement payment for a motor vehicle that does not have a lien or encumbrance, the insurance company or its agent may request the Department of Revenue to issue a salvage certificate of title or a parts-only certificate of title for the vehicle.

(b) The request under paragraph (a) of this subsection shall:

(i) Be submitted on each form required by and provided by the Department of Revenue;

(ii) Document that the insurance company has made at least two (2) written attempts to obtain the certificate of title and include the documentation with the request;

(iii) Include any fees applicable to the issuance of a salvage certificate of title or a parts-only certificate of title; and

(iv) Be signed under penalty of perjury.

(6)(a) If an insurance company is unable to obtain the properly endorsed certificate of title within thirty (30) days after disbursing a total loss settlement payment for a motor vehicle that has a lien or encumbrance, the insurance company or its agent shall submit documentation to the Department of Revenue from the claims file that establishes the lienholder's interest was protected in the total loss indemnity payment for the claim.

(b) The documentation under paragraph (a) of this subsection shall be:

(i) Submitted with a request for a salvage certificate of title or a parts-only certificate of title for the vehicle; and

(ii) The requirements under subsection (5)(b) of this section.

(7) Upon receipt of a properly endorsed certificate of title or a properly executed request under subsection (5) of this section, the Department of Revenue shall issue a salvage certificate of title or a parts-only certificate of title for the vehicle in the name of the insurance company.

(8) The Department of Revenue may promulgate rules, regulations and forms for the administration of subsections (4) through (6) of this section.

(9) This section shall stand repealed on July 1, 2014.

SOURCES: Laws, 2007, ch. 594, § 1; Laws, 2009, ch. 461, § 1; Laws, 2012, ch. 392, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment substituted "Department of Revenue" for "Mississippi State Tax Commission" in (2); and added (4) through (9).

CHAPTER 17

Insurance Agents, Solicitors, or Adjusters

Article 9.

Licensing of Insurance Adjusters.

§ 83-17-401. Definitions.

As used in this article, unless the context otherwise requires:

(a) "Adjuster" means any person who, as an independent contractor, or as an employee of an independent contractor, adjustment bureau, association, insurance company or corporation, managing general agent or self-insured, investigates or adjusts losses on behalf of either an insurer or a self-insured, or any person who supervises the handling of claims. "Adjuster" shall not include:

(i) An attorney-at-law who adjusts insurance losses from time to time and incidental to the practice of law, and who does not advertise or represent that he is an adjuster;

(ii) A salaried employee of an insurer who is regularly engaged in the adjustment, investigation or supervision of insurance claims;

(iii) Persons employed only for the purpose of furnishing technical assistance to a licensed adjuster, including, but not limited to, photographers, estimators, private detectives, engineers, handwriting experts and attorneys-at-law;

(iv) A licensed agent or general agent of an authorized insurer who processes undisputed or uncontested losses, or both, for such insurer under policies issued by the licensed agent or general agent;

(v) A person who performs clerical duties with no negotiations with the parties on disputed or contested claims, or both;

(vi) Any person who handles claims arising under life, accident and health insurance policies;

(vii) Any person who is a multiperil crop insurance adjuster; or

(viii) Any person who collects claim information from, or furnishes claim information to, insureds or claimants, and who performs data entry including entering data into an automated claims adjudication system, if the person is an employee of a licensed independent adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed independent adjuster or licensed agent. A licensed agent who is acting as a supervisor and adjusting portable electronics insurance claims in accordance with this subparagraph does not need to be licensed as an adjuster.

(b) "Insurer" means any insurance company or self-insured.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims which:

(i) May only be utilized by a licensed independent adjuster, licensed agent or supervised persons operating in accordance with paragraph (a)(viii) of this section; and

(ii) Must comply with all claims payment requirements of the insurance code; and must be certified as compliant with this section by a licensed independent adjuster that is an officer of a licensed business entity under this chapter.

SOURCES: Laws, 1993, ch. 433, § 1; Laws, 2011, ch. 474, § 1; Laws, 2012, ch. 313, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added (a)(viii); added (d); and made minor stylistic changes.

§ 83-17-407. Waiver of license requirement for adjuster licensed in another state; prohibition against denial of reciprocity for applicant licensed in another state solely because applicant is not resident of the United States.

The commissioner may waive any license requirement for an applicant with a valid license from another state having license requirements substantially equivalent to those of this state. No applicant with a valid license from another state shall be rejected solely on the basis that the individual is not a resident of the United States of America.

SOURCES: Laws, 1993, ch. 433, § 4; Laws, 2012, ch. 313, § 2, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added the last sentence.

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